

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

=62-046515

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 128 Primary Registration District No. 2000 Registrar's No. 1930

**FILED JAN 2 1963**  
1. PLACE OF DEATH  
a. COUNTY **GREENE**

b. CITY (If outside corporate limits, give TOWNSHIP only)  
OR TOWN **SPRINGFIELD** Length of stay in 1b

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION **Kimbrough Nursing Home**  
**519 Cherry** Inside Limits Yes ☒ No ☐

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)  
a. STATE **Missouri** b. COUNTY **GREENE**

c. CITY OR TOWN **SPRINGFIELD** Inside Limits Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location) **1234 E. Meadowmere** Reside on Farm Yes ☐ No ☒

3. NAME OF DECEASED First Middle Last  
(Type or print) **CLARENCE J. CHAPIN**

4. DATE OF DEATH Month Day Year  
**December 30, 1962**

5. SEX **Male**

6. COLOR OR RACE **White**

7. Married ☐ Never Married ☐  
Widowed ☒ Divorced ☐

8. DATE OF BIRTH **12/29/1875**

9. AGE (last birthday) **87**  
IF UNDER 1 YEAR IF UNDER 24 HR  
Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  
**Scale Inspector**

10b. KIND OF BUSINESS OR INDUSTRY  
**Retired**

11. BIRTHPLACE (City and state or country)  
**Missouri**

12. CITIZEN OF WHAT COUNTRY  
**USA**

13a. FATHER'S NAME

**Daniel F. Chapin**

13b. MOTHER'S MAIDEN NAME

**Genette Maynard**

14. NAME OF HUSBAND OR WIFE

**Deceased**

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)  
**No**

16. SOCIAL SECURITY NO.

17. INFORMANT Address  
**Mrs. John Fairman (Daughter) Springfield, Mo.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Heart disease, atherosclerotic**

INTERVAL BETWEEN ONSET AND DEATH  
**yes**

DUE TO (b)

**Malnutrition**

DUE TO (c)

**Sanitary & Cachexia**

**yes**

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from **24 Dec 62** to **12/30/62** and last saw him alive on **29 Dec 62**  
Death occurred at **3:25** P.m. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title)  
**Emmett E. Knapp, M.D.**

22b. ADDRESS **1630 N. Jefferson Missouri**

22c. DATE SIGNED  
**31 Dec 62**

23a. BURIAL, CREMATION, REMOVAL (Specify)  
**Removal-Burial**

23b. DATE  
**1-1-63**

23c. NAME OF CEMETERY OR CREMATORY  
**Edgewood Cemetery**

23d. LOCATION (City, town, or county) (State)  
**Chillicothe, Missouri**

24. FUNERAL DIRECTOR  
**KLINGNER MORTUARY, INC**

ADDRESS  
**SPRINGFIELD Mo.**

25. DATE RECD. BY LOCAL REG.  
**12-21-62**

26. REGISTRAR'S SIGNATURE  
**Effie S. Meeton**

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

DATE AMENDED

VS 300  
Rev. 4/59

**0397**

**0397**

3

4 **0**

5 **2**

6

7 **0**

8 **2**

**94200**

10

11

**1286-0**

13

JAN 10 1963

JAN 4 1963

Permit 14-31-62

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Max Rhodes*

Licensed Embalmer No. \_\_\_\_\_

4071

P. O. Address \_\_\_\_\_

*[Signature]*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.